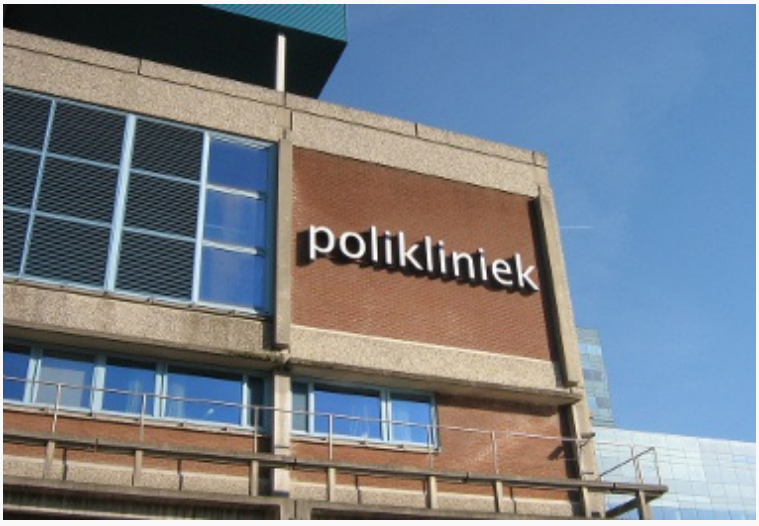
Health reforms in the Netherlands have increased access to health care, but have also led to an unexpected growth in health spending.

Blog Admin

The Netherlands implemented major reforms to its health care system in 2006. **Ilaria Mosca** *assesses the consequences of the reform programme, noting that while there have been improvements to service delivery, there have also been negative consequences such as an increase in overall health spending. There are still some key problems which need to be resolved if the system is to provide the benefits which were originally envisaged.*

The Dutch health care reform implemented in 2006 showed that introducing regulated competition in a typically government-run sector was feasible. The rationale of the change was that the government would stimulate competition rather than strongly regulate the supply of health care. The widespread interest raised by the Dutch experiment is visible in other countries such as the United States. Many American policymakers looked closely at the universal health insurance mandate of the Netherlands. Indeed some parts of the Affordable Care Act – the so-called 'Obamacare' bill – do resemble the Dutch experiment.

Prior to the reform, the Dutch system had strong government regulation and an inefficient dual system of public and private insurance. This led to several issues. First, long waiting lists were the rule of the day because of the strict rationing implemented by the government. Second, there was no information available on the quality of health care delivery. Third, patients falling under the sickness fund scheme – roughly two thirds of the population – could not switch across health care providers, and high-risk privately insured patients had limited access to health insurance. The 2006 reform had several goals: cost containment, efficiency, better quality of care, and accessibility to the health care system. The health policy agenda is far from being completed and is a work in progress subject to continuous changes and influences from the underlying political mainstream.



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A quick scan of the 2006 reform, seven years after its implementation, shows significant improvements in the accessibility of health care services and the availability of health (quality) information. It has been, however, less successful on other fronts such as cost containment and efficiency. The individual health insurance mandate guarantees full coverage to the whole population. Every person living or working in the Netherlands has to take out insurance – the only exception is people younger than 18 who are automatically covered and entitled to receive health services. Financial accessibility – measured in out-of-pocket expenditure – is among the lowest across OECD countries, at less than 7 percentage points of total health care spending. Waiting lists were consistently reduced from the year 2000 and most of them are now below the so-called 'agreed acceptable standards'.

The lack of clear and available information was tackled with the 2006 reform. The launch of several

websites (such as kiesbeter.nl) partly helped to achieve the goal of information transparency, which is a prerequisite for consumer choice. The use of patient-reported indicators and the set-up of a national quality programme by the Ministry of Health to develop quality information for health care purchasers, i.e. health insurers, were further steps towards making information more transparent. There is, however, still room for improvement. Negotiations between insurers and providers do not always focus on the quality of care because of missing quality information on performance indicators and low data reliability.

Perhaps one of the most unexpected – and unwanted – trends following the reform is the steady growth of health care spending. The latest OECD figures show that 11.9 per cent of GDP is spent on health, which is second only to the United States (17 per cent). Long-term care and hospital care caused health care expenditures to increase dramatically. In 2011 a total of € 90 billion were spent on health care. Most of the spending was on hospital care and long-term care: € 23.6 billion and € 16.1 billion respectively. Between 2000 and 2011 four sectors significantly increased their share in the national health spending budget: hospital care (from 24 per cent to 26.2 per cent), dental care (from 4.8 per cent to 5.1 per cent), mental health care (from 5.5 per cent to 6.1 per cent) and care for the handicapped and disabled (from 8.5 per cent to 9.3 per cent). The profits of self-employed doctors, such as medical specialists with their own practice as well as GPs, rose by 8 per cent and 5.7 per cent respectively between 2001 and 2009. The government's answer to these cost overruns has been – in some cases – to set a legal 'macrobudget instrument' to guarantee that the total hospital expenditure does not exceed a certain amount in a year. Needless to say, the constant growth of health care costs received significant attention in the elections in the Netherlands last September. The financial sustainability of the Dutch health care system is at risk and no day passes by without news on the health care agenda.

For example, a recent report of the Netherlands Bureau of Economic Policy Analysis (CPB) raised issues on the long-term sustainability of health care in the Netherlands. Solidarity might be at stake in the future because highly-educated individuals fund health care much more, but consume fewer health care services than poorly-educated individuals. According to the CPB's calculations highly-educated people spend €4,000 a year to receive €2,000 back in care services. The poorly-educated spend €2,000 a year but receive health care worth €3,000. Further attempts by the new coalition government to introduce an income-dependent health insurance premium – which is currently community rated – raised fierce objections and fell off the political radar fairly quickly.

It is clear that the health agenda in the Netherlands is still unfinished. Several topics will surely keep playing an important role in the political discussions ahead: how to guarantee financial sustainability in the long-term, how to maintain accessibility while facing rises in the level of private payments, how to implement deregulation and the need to control costs.

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